only 14 to 27 percent of patients with a history of penicillin allergy may actually have IgE antibodies. In patients with negative skin tests with both BPO-PPL and MDM, penicillin administration has not caused immediate or accelerated allergic reactions. Since neither MDM nor BPO-PPL are commercially available, routine skin testing is still not possible. Until these reagents become available, clinicians must rely on the patient's history despite its fallibility.

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## Bronchiolitis—A Stage of Incipient Bronchial Asthma?

BRONCHIOLITIS is an important cause of acute lower respiratory tract disease in infants. Hall marks of the disease include: (1) an acute onset of respiratory distress with sibilant rales and wheezes, (2) evidence of obstructive pulmonary hyperinflation clinically and by radiologic examination, (3) normal temperature or low-grade fever, (4) absence of past history of wheezing. A viral infection, particularly respiratory syncytial virus, is thought to be the most important cause. Differentiation from bronchial asthma is not easy, since bronchial smooth muscle responsiveness to bronchodilators is not good in this age group. Retrospective studies have suggested that in 30 to 50 percent of children with bronchiolitis, bronchial asthma develops later in childhood.

Two recent prospective studies revealed that 50 percent of these children, when followed five to eight years after the initial episode, had recurrent wheezing. Important prognostic indicators include: (1) positive family history of atopy, (2) other allergic manifestations (for example, hay fever, atopic dermatitis), (3) nasal eosinophilia, and (4) significantly positive reaction to skin tests with common inhalant allergens. It is postulated that patients with an atopic diathesis are more likely to have wheezing with a viral respiratory infection. However, further epidemiological work on the effects of respiratory viral infections on the non-atopic patients is needed to confirm this impression.

These studies strongly suggest that bronchiolitis is frequently followed by asthma, particularly in infants with other markers of the atopic state. Prophylactic measures aimed at lessening allergenic exposure at this critical period should be evaluated to determine whether the prognosis can be altered.

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## Pitfalls in the Use of Skin Testing in Allergy

TWO RECENT REPORTS deal with some of the pitfalls in allergy skin testing. One of these reemphasizes what has been known for some time but is often lost sight of—that positive skin tests alone do not reflect active clinical allergy. Whitcomb tested 50 medical students, taken at random, for sensitivity to nine inhalants and eight food allergens. Almost two-thirds of them (32) had positive reactions (two plus or more). In all there were 100 such positive reactions, 84 to inhalants and 16 to foods. No one reacted to food tests alone. Only about half (17) of the 32 who had positive tests had experienced clinical symptoms in the preceding year. The discovery of positive reactions came as a surprise to the other half. It would seem that either their challenge with the antigens concerned was insufficient or some other factor in the allergic response was missing.

Allergists have differed in their opinion about the extent to which drugs used in treatment of allergic disease affect skin tests. The matter has recently been reinvestigated. Hydroxyzine, (Atarax®, Vistaril®), diphenhydramine (Benadryl®) and chlorpheniramine (Chlor-Trimeton®, Teldrin®) produced significant skin test inhibition. The effect of hydroxyzine was profound at one hour after drug administration and was still present at 24 hours. Ephedrine, aminophylline and prednisone had no effect on the skin tests. It is concluded that antihistamines and hydroxyzine should be discontinued for at least 24 hours before skin testing.

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